

POC PROVIDER AGREEMENT for**WEEKLY LONG TERM–PERSONAL CARE SERVICES / ELDERLY and DISABLED ADULT WAIVER–COMPANION SERVICES / ADULT DAY HEALTH CARE SERVICES****SUPPORT COORDINATION OR SINGLE POINT OF ENTRY AGENCY NAME & TELEPHONE #:** _____**PARTICIPANT NAME:** _____ **MEDICAID ID #:** _____ **DATE DEVELOPED:** _____

This Participant Schedule is subject to change depending on the participant's preferences and fluctuations in his/her personal schedule. Therefore the anticipated schedule on the approved POC Task List and/or POC and Individualized Service Plan shall not be used for audit or monitoring purposes. Weekly allocations are to be used flexibly, in accordance with the participant's preferences and personal schedule within the week that begins on Sunday @ 12:00 a.m., and ends on the following Sunday @ 12: 00 a.m. Allocations are to be used within the prescribed week only. Unused portions of a weekly allocation cannot be saved or borrowed from one week for use in another week. Total hours used within the week may not exceed the prior authorized weekly allocation. Total number of days of ADHC attendance may not exceed the prior authorized weekly allocation.

X _____ X _____
☐ Participants or ☐ Personal Representative's Signature and Date Support Coordinator's or Assessor's Printed Name and Signature and Date

☐ We agree to provide services/supports in accordance with the approved POC Task List and/or POC and Individualized Service Plan. Completion of the provider number(s) section(s) below denotes type(s) of service to be provided.

*If you (Provider) do not agree to provide services/supports in accordance with the approved POC Task List and/or POC and Individualized Service Plan, you must submit written documentation that supports your inability to meet the individual's health and welfare needs, or to support that all previous efforts to provide services/supports have failed, and that there is no option but to refuse service provision.

☐ If not agreeing to provide services to this participant, I (Provider) have attached requested information.

X _____
Provider Agency Printed Name and Numbers LT-PCS Provider # EDA-CS Provider # ADHC Provider #

X _____
2nd Provider Agency Printed Name and Numbers (if applicable) LT-PCS Provider # EDA-CS Provider # ADHC Provider #

X _____
Pre-Approval Provider Agency Representative Printed Name and Title and Signature and Date

X _____
2nd Pre-Approval Provider Agency Representative Printed Name and Title and Signature and Date (if applicable)

X _____
OAAS Regional Office Representative Approval Signature and Date

X _____
Post-Approval Provider Agency Representative Printed Name and Title and Signature and Date

X _____
2nd Post-Approval Provider Agency Representative Printed Name and Title and Signature and Date (if applicable)